IMMUNOLOGY CASE REGISTRY

USER MANUAL

Version 2.1

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Department of Veterans Affairs
V*IST*A Technical Services

Table of Contents

I. Introduction

The Immunology Case Registry (ICR) application supports the maintenance of local and national registries for clinical and resource tracking of Human Immuno-deficiency Virus (HIV/AIDS) disease. This version of the Immunology Case Registry Package provides many capabilities to VA Medical Centers that provide care to immune deficiency patients. The software supports the categorization of patients with HIV disease, generates reports to the Center for Disease Control (CDC), and automatically extracts data for inclusion in the VA's National Immunology Case Registry. It also provides several clinical and administrative reports for medical center use.

The Immunology Case Registry Package accesses several other V*IST*A files which contain information concerning diagnosis, prescriptions, laboratory tests, radiology exams, hospital admissions, and clinic visits. This allows clinical staff to take advantage of the wealth of clinical data supported through V*IST*A.

Functionality:

- Creates a simple process for entering and tracking a patient into the registry. Users need only identify the patient and determine the disease category for that patient. Virtually all other data employed by the ICR module is accessed through the other V*IST*A packages (e.g., Pharmacy, Laboratory, Dental, and Radiology).

- Provides security in addition to that provided by the Kernel and VA FileMan to ensure patient confidentiality. Patient identifying information is automatically encrypted for transmission to the National Registry. Names are never transmitted.

- Provides data extracts for uploading to a National Registry. The National Registry is used to provide VA-wide review of patient demographics, clinical aspects of disease, and resource utilization involved in providing care to patients.

- Provides a variety of management reports for local use, including patients lost to follow-up, frequency of visits, and volume of lab tests and prescriptions per patient.

- Audits user access to patient data for patients in the registry.

- For the Medical Center's local Immunology Case Registry:

  Categorizes patients according to severity of HIV disease.

  Collects data necessary for reporting of AIDS cases to the Center for Disease Control. Automatically generates CDC forms for patients categorized as AIDS patients.

  Lists patients who have not been seen at the medical center for a specified length of time.

  Generates resource utilization reports.

II. Implementation and Maintenance

Checklist

This chapter provides guidelines for implementing the Immunology Case Registry application. The Immunology Case Registry package was mandated for installation by circular 10-91-142 on Dec. 2, 1991. It is important that IRM or the ADPAC completes all of the steps contained in this chapter before assigning menu options to clinical staff.

Immunology Case Registry is found in the IMR namespace. All routines, templates and options begin with the letters IMR. File numbers are in the range of 158 to 158.95 and are stored in the ^IMR global.

Steps to Follow

☐ Editing site configurable files.

a. The Enter/Edit Immunology Study Site Parameters option edits the IMR Site Parameters (#158.9) file.

[1]b. The Link Local Lab to National Lab File option links lab tests to the National Lab File (WKLD file #64).

Review the above populated site configurable files. The options which allow the application coordinator to edit the file's data are all located in the Immunology Study Management Menu (i.e., ICR Site Management Functions).

☐ Queueing TaskMan jobs.

The Extract Data for Immunology Study Registry [IMR REGISTRY DATA] option should be queued to run nightly at 6:00 pm or later. The ADPAC may queue this option to run via the Queue Registry Data Collection [IMR QUE DATA COLLECT] option or the IRMS support person may use the Schedule/Unschedule Options option to queue the IMR Registry Data option to run.

Note: There is no need to schedule this task to run in your test account.

[1] Patch IMR*2.1*8 Option name and functionality changed.

☐ Accessing menus.

Access to the package is restricted to holders of the security keys associated with the package. The keys are required for access to the files, as well as utilization of the routines. Attempts to access the files or use the routines without the proper security keys results in an entry in the IMR Access Violations (#158.8) file which identifies the individual, date and time, and the attempted access. Access violations are also recorded in the facility's error trap.

There are two security keys in this application:
IMRA - This is a general key for access to the ICR Package.
IMRMGR - This is the key held by the individual(s) in charge of the ICR Package at their facility.

☐ Assigning menus.

The Immunology Study Management Menu contains the following menus or options:

```
ICR PACKAGE VERSION 2.1

          ICR Site Management Functions ...
          Reports Menu (ICR) ...
          General Immunology Study Menu ...
          Delete an Entry from the Case Study File
          Create Search Template Containing Study Members
          Lab Test Specification for Immunology
          Specification of Drugs for Immunology
          Encryption of Data (Demonstration)
```

Clinical staff should be assigned the 2nd and 3rd options (i.e., Reports Menu (ICR) and General Immunology Study Menu). The other options should be assigned to the Immunology Case Registry application coordinator.

☐ Printer issues.

The user should select certain printers to be set up as allowable (secure) printers in the ICR Site Parameter (#158.9) file. If the user attempts printing to a non-secure printer, then the output will be replaced by an error message indicating that the output can only be directed to a secure printer. However, users can print their output to a printer that is "slaved" to their terminal.

☐ Domain.

The IMMUNOLOGY.VA.GOV domain must be set-up in the Domain (#4.2) file for each facility. If no such entry exists, contact your CIO Field Office customer support representative to find out what values are needed; then use the Enter/edit functionality of FileMan to create the entry.

Options for Implementation and Maintenance

These options are for IRM or ADPAC use only.

ICR Site Management Functions (IMR MENU (SITE SETUP))

Description:

This menu contains options directly related to initialization of the site parameter file and other functions for overseeing the package.

This menu should be given to the Immunology Case Registry application coordinator. The user must have the IMRMGR key to use any of the options in this menu.

Menu Display:

```
Enter/Edit Immunology Study Site Parameters
Queue Registry Data Collection
Show users with access to 'ICR' keys
Access Violation Log
List Search Templates for Package
Delete a Package Search Template
Current Inpatient List (Queue This Option)
```

Enter/Edit Immunology Study Site Parameters (IMR SPF ENTER/EDIT)

Description:

This option is used to maintain the site specific information for the Immunology Case Study data file(s).

Field Descriptions:

Activate 'Name' Pointer:
This field is available to the ICR Application Coordinator to be able to provide a pointer to the patient's identity within the Patient file. This is primarily designed for those sites which have been using a prior version of ICR software, and may have templates and/or routines which depend upon a pointer to the Patient file within the Immunology Case Study file, since prior versions were pointers to the Patient file. If the 'Yes' response is selected, the 'Name' field will be set to the pointer to the Patient file for each patient. This pointer is not encrypted. This means that a user with programmer's access to the database can determine the identity of patients in the Immunology Case Study file. If the 'Yes' response is deleted from this field, the 'Name' field will be deleted from each file entry.

If 'Yes' is selected at this prompt -- references to the '#.01:' field in locally developed routines and templates should be changed to '#103.01:' because of the patient identity issue.

Last Start Time:
This is the start date/time the data extract was last run. This is a non-editable field.

Last Completion Time:
This is the completion date/time of the last data extract. This is a non-editable field.

Coordinator(s):
The individual or individuals indicated here will be included as recipients of data collection mail messages that are produced. Other individuals may also hold one or more of the ICR keys which provide access to the ICR options, but the individuals indicated here should be the one(s) primarily responsible for the HIV data collection within V*IST*A.

> **Put On Mail List:**
> This field, if set to yes, will result in this coordinator receiving any data collection messages which are generated for the National Registry. **This may be set to Yes for a few days to see the type(s) of messages generated and then set to No, until otherwise desired.**

Country:
This is the country in which the facility is located. This data is used on the CDC form.

City:
This is the city in which the facility is located. This data is used on the CDC form.

State:
This is the state in which the facility is located. This data is used on the CDC form.

Zip Code:
This is the zip code for the facility. This data is used on the CDC form.

Station Name:
This is the station name for the facility. This data is used on the CDC form.

Default Telephone Number:
This is the default telephone number for the individual filling out the CDC form. This data is used on the CDC form.

Last Physician Number:
This field is used to hold the last physician telephone number for printing on the CDC form cover page. The last physician number cuts down the number of times a number must be entered.

Allowable Printers:
Enter allowable (secured) printers on which to print reports containing sensitive data.

Site Street Address 1:
This should contain the first line of the street address of the facility. This data is used on the CDC form.

[1]Lab Group Name:
All of the laboratory tests for Immunology have been grouped by test type (Immunology Lab Group Name file #158.95) as shown in the following list. Select the first lab group whose tests you want to link to the National Lab File tests.

```
BLOOD COUNTS
CD4
CHEMISTRY GENERAL
CHEMISTRY LIVER
HIV ANTIBODY
LIPIDS
SEROLOGY - HEPATITIS
SEROLOGY - OTHER
VIRAL LOAD
```

Type of Lab Test:
Then within that group, select the type of lab test (Immunology Lab Type of Test file #158.96). (See Appendix B (ICR Lab Groups and Lab Test Names for a list of lab tests within each group.)

```
ALBUMIN
ALKALINE PHOSPHATASE
ALT (ALANINE TRANSFERASE)
AMYLASE
AST (ASPARTATE TRANSFERASE)
CD4 COUNT (ABSOLUTE)
CD4 PERCENT
CMV (CYTOMEGALOVIRUS)
CREATINE PHOSPHOKINASE (CPK)
CREATININE
ELISA
G6PD (GLUCOSE-6-PHOSPHODEHYDRO
GLUCOSE
HDL (HIGH DENSITY LIPOPROTEINS
HEMATOCRIT
HEMOGLOBIN
HEPBCAB (HEPATITIS B CORE ANTI
```

[1] Patch IMR*2.1*8 Lab Group Name through National Lab File Link added.

```
HEPBSAB (HEPATITIS B SURFACE A
HEPBSAG (HEPATITIS B SURFACE A
HEPCAB (HEPATITIS C ANTIBODY)
HGBA1C (GLYCOHEMOGLOBIN)
IFA (IMMUNOFLUORESCENT ANTIBOD
LACTATE DEHYDROGENASE (LDH)
LDL (LOW DENSITY LIPOPROTEINS)
QUALITATIVE
QUANTITATIVE
QUANTITATIVE, ULTRA
RPR (SYPHILIS)
TOTAL BILIRUBIN
TOTAL CHOLESTEROL
TOXOPLASMA
TRIGLYCERIDES
VDRL (SYPHILIS)
WESTERN BLOT
WHITE BLOOD CELL - PERCENT NEU
WHITE BLOOD CELL COUNT
```

Local Lab File Name:
Then select a locally named lab test from the Laboratory Test file #60 that corresponds to the Type of Lab Test you selected. See Appendix A (Worksheet for Lab Test Link, column one for a list of lab test names to help you make your selection. **Note: Your test names may differ from those in column one.**

National Lab File Link:
If you completed the worksheet, Appendix A (Worksheet for Lab Test Link, this is a lab test name or workload code that you entered in column four or column five respectively from your local WKLD Code file #64 also known as the National Lab File.

After entering the National Lab File Link, you are returned to the previous prompt Local Lab File Name so you can enter another for the Type of Lab Test. When you have completed all your National Lab File Links for the selected Type of Lab Test, press the <RET> key to bypass the "Select LOCAL LAB FILE NAME" prompt and enter a new Type of Lab Test for the selected Lab Group.

Queue Registry Data Collection (IMR QUE DATA COLLECT)

Description:

This option is used to queue the Extract Data for Immunology Study Registry [IMR REGISTRY DATA] to run. The Extract Data for Immunology Study Registry option extracts data identified by the Focus Group. These data elements are prepared and transmitted to the National Registry nightly.

Note: The IRM support person can directly schedule the Extract Data for Immunology Study Registry option to run through the KERNEL Schedule/ Unschedule Options option.

Field Descriptions:

This option automatically queues the data collection for the National HIV Registry. The default time is Today at 6:00 PM, and every 24 hours thereafter. The following is the message that appears when running this option:

The National Registry Data Collection has been queued to run at *day@time*
and will be automatically requeued at 24 hour intervals.

Show users with access to 'ICR' keys (IMR KEYS)

Description:

This option is used by the ICR application coordinator, or equivalent, to examine which users hold the ICR keys.

This software contains 2 security keys: IMRA and IMRMGR.

Report Description:

This option lists the holders of each of the ICR keys on the screen.

Access Violation Log (IMR ACCESS LOG)

Description:

This option is used to list any access violations in the ICR package, and to delete any entries over 30 days old.

Access violations are recorded when an individual who does not have a proper key (IMRA and/or IMRMGR) for a file or routine either attempts to use the routine or access an entry in the file. The access is recorded in this list and is recorded in the system error trap as the result of a reference to an non-existent line.

In most cases these violations would have to occur at the programmer access level, since all of the options (except those used by Laboratory and Pharmacy to initialize the Drug and Lab Test sub-files of the Site Parameter File) are protected by a security key.

Field/Report Descriptions:

The user may do one of the following:

1. List Access Violations
2. Delete Entries from the file

1. List Access Violations:

This option displays the following information on the screen:

Date of access violation.
Time of access violation.
Identification of the user who had the violation.
What file or option the user was accessing when the violation occurred.

For each entry on this list there should be a complete listing of the current local variables in the system error log, which may provide more information on these access attempts.

2. Delete Entries from the file:

Entries over 30 days old are automatically deleted, and the following message appears:

All entries over 30 days old have been removed.

List Search Templates for Package (IMR TEMPLATE LIST)

Description:

This option can be used to produce a listing of the search template names which have been created for this package, including the user who created the template, the date it was created, and the last date on which it was referenced.

Report Description:

This option displays the following information on the screen:

Name of the template.
Who created the template.
Date the template was created.
Date the template was last used.

Delete a Package Search Template (IMR TEMPLATE DELETE)

Description:

This option may be used to delete a specific search template which has been created using this package.

Field Descriptions:

The user is asked to enter the name of a search template to be deleted, then the search template is deleted.

Current Inpatient List (Queue This Option) (IMR QUEUED INPAT LIST)

Description:

This option schedules the Current Inpatients Report [IMR INPAT LIST] to run daily at a user defined time.

This option does not require the person who queues it to hold an ICR package key.
It does require that the printer selected for output be one of those selected as an allowable printer in the ICR Site Parameters (#158.9) file. If the printer specified is not a secure printer, then the output will be replaced by an error message indicating that the output can only be directed to a secure printer.

Field Descriptions:

Do you really want to queue this option to run daily?
'Yes' means you want to queue this option to run daily, 'No' means you want to quit this option.

Device:
Select a device for the report to print on. This must be a secured printer.

Queue this option to run when:
Enter a time (e.g., 6p) for the queued option to run. The run time must be at least 2 minutes in the future, (i.e., NOW cannot be used).

The following message appears:
The Current Inpatient List is now scheduled to print each day at
time* on device *device
beginning on *today's date*

Note: If you wish to stop this report from being queued to run, you must contact an IRMS representative.

III. Package Operation

Having completed the instructions for implementing the software as indicated in the previous chapters, you are now ready to use the options. The content contained in the following chapters provides information on all software options which can be used by IRMS, clinical staff managers, and clinical staff. This information includes the name, description or purpose of the option, menu access, and field descriptions.

Remember that on-line help is available when questions arise. The user can type ? or ??, after any prompt to get a help message that generally tells the user what to do. In some instances, a specific list of possible responses is displayed. All field names in the Immunology Case Registry application have descriptions associated with them. Help is also available at the menu level by typing a ??, ???, or ?OPTION.

IV. Immunology Study Management Menu

Immunology Study Management Menu (IMR MENU (MANAGEMENT))

Description:

This menu is used to access those functions necessary to manage the Immunology Case Registry package. This menu is for IRM or ADPAC use only.

This menu should be given to the Immunology Case Registry application coordinator. The user must have the IMRMGR key to use any of the options in this menu.

Menu Display:

```
ICR PACKAGE VERSION 2.1



          ICR Site Management Functions ...
          Reports Menu (ICR) ...
          General Immunology Study Menu ...
          Delete an Entry from the Case Study File
          Create Search Template Containing Study Members
          Lab Test Specification for Immunology
          Encryption of Data (Demonstration)
```

Delete an Entry from the Case Study File (IMR DELETE ENTRY)

Description:

This option allows an individual with the IMRMGR key to delete an incorrect entry from the Immunology Case Study (#158) file.

Warning: This option will delete all information in File 158 relative to the patient. In addition, it will send a message to the National Registry to indicate that information concerning the selected patient should be deleted from the National Registry.

Field Descriptions:

The user sees the following message when entering the option:
Be absolutely sure before using this option -- it will delete all data for the specified individual from the immunology case file

Patient Name:
Enter the patient's name, last name first.

Are You Absolutely Sure?
Answer 'Yes' or 'No'.

Create Search Template Containing Study Members (IMR SEARCH TEMPLATE)

Description:

This option is used to create a search template. This search template will contain all of the members of the Immunology Case Study file, and can be used to access data from the Patient file and related files on these patients. The search template is used in conjunction with the File Manager 'Print' option, and is specified at the first request to sort by as: SORT BY: NAME// [TEMPLATE NAME where TEMPLATE NAME would be the name specified by the creator of the template. For security reasons, the name of the template should not contain any references to HIV or AIDS. This will limit the output to entries in the Patient file who are also included in the Immunology Case Study file. You will then be asked to specify what additional field you wish to sort by, as in a normal sort specification.

The sort template contains only the results of the search (the members of the file), and does not indicate on what basis these entries were selected, in contrast to the sort template generated by a regular search which can be used to perform another search if desired.

Field Descriptions:

The user sees the following message when entering the option:

Enter a non-descriptive sort template name that will contain the patient identities:
Enter a name for the sort template which doesn't contain any reference to HIV or AIDS.

Do you want to Queue this task (it may take a while)?
The user may queue this task. Answer 'Yes' or 'No'.

Requested Start Time:
Requested time to start the task.

[1]Link Local Lab to National Lab File (IMR LAB TEST ENTRY)

Description:

This option is available for the HIV Coordinator with help from the Clinical Laboratory Coordinator to link lab tests on the local system to the National Lab File (WKLD Code file #64). Complete the worksheet in Appendix A (Worksheet for Lab Test Link) before using this option.

Field Descriptions:

Lab Group Name:
All of the laboratory tests for Immunology have been grouped by test type (Immunology Lab Group Name file #158.95) as shown in the following list. Select the first lab group whose tests you want to link to the National Lab File tests.

```
BLOOD COUNTS
CD4
CHEMISTRY GENERAL
CHEMISTRY LIVER
HIV ANTIBODY
LIPIDS
SEROLOGY - HEPATITIS
SEROLOGY - OTHER
VIRAL LOAD
```

Type of Lab Test:
Then within that group, select the type of lab test (Immunology Lab Type of Test file #158.96). (See Appendix B (ICR Lab Groups and Lab Test Names for a list of lab tests within each group.)

```
ALBUMIN
ALKALINE PHOSPHATASE
ALT (ALANINE TRANSFERASE)
AMYLASE
AST (ASPARTATE TRANSFERASE)
CD4 COUNT (ABSOLUTE)
CD4 PERCENT
CMV (CYTOMEGALOVIRUS)
CREATINE PHOSPHOKINASE (CPK)
CREATININE
ELISA
G6PD (GLUCOSE-6-PHOSPHODEHYDRO
GLUCOSE
HDL (HIGH DENSITY LIPOPROTEINS
HEMATOCRIT
HEMOGLOBIN
HEPBCAB (HEPATITIS B CORE ANTI
HEPBSAB (HEPATITIS B SURFACE A
HEPBSAG (HEPATITIS B SURFACE A
HEPCAB (HEPATITIS C ANTIBODY)
HGBA1C (GLYCOHEMOGLOBIN)
IFA (IMMUNOFLUORESCENT ANTIBOD
LACTATE DEHYDROGENASE (LDH)
LDL (LOW DENSITY LIPOPROTEINS)
QUALITATIVE
QUANTITATIVE
QUANTITATIVE, ULTRA
RPR (SYPHILIS)
TOTAL BILIRUBIN
TOTAL CHOLESTEROL
```

[1] Patch IMR*2.1*8 Option name and functionality changed.

```
TOXOPLASMA
TRIGLYCERIDES
VDRL (SYPHILIS)
WESTERN BLOT
WHITE BLOOD CELL - PERCENT NEU
WHITE BLOOD CELL COUNT
```

Local Lab File Name:
Then select a locally named lab test from the Laboratory Test file #60 that corresponds to the Type of Lab Test you selected. See Appendix A (Worksheet for Lab Test Link, column one for a list of lab test names to help you make your selection. **Note: Your test names may differ from those in column one.**

National Lab File Link:
If you completed the worksheet, Appendix A (Worksheet for Lab Test Link, this is a lab test name or workload code that you entered in column four or column five respectively from your local WKLD Code file #64 also known as the National Lab File.

After entering the National Lab File Link, you are returned to the previous prompt Local Lab File Name so you can enter another for the Type of Lab Test. When you have completed all your National Lab File Links for the selected Type of Lab Test, press the <RET> key to bypass the "Select LOCAL LAB FILE NAME" prompt and enter a new Type of Lab Test for the selected Lab Group.

Example using Viral Load:

```
Link Local Lab to National Lab File
Select LAB GROUP NAME: ??

Choose from:
   BLOOD COUNTS
   CD4
   CHEMISTRY GENERAL
   CHEMISTRY LIVER
   HIV ANTIBODY
   LIPIDS
   SEROLOGY - HEPATITIS
   SEROLOGY - OTHER
   VIRAL LOAD

Select LAB GROUP NAME: VIRAL LOAD
Select TYPE OF LAB TEST: ??
     This is the type of Lab test.

Choose from:
   QUALITATIVE
   QUANTITATIVE
   QUANTITATIVE, ULTRA

Select TYPE OF LAB TEST: QUANT
     1   QUANTITATIVE
     2   QUANTITATIVE, ULTRA
CHOOSE 1-2: 1  QUANTITATIVE
  Are you adding 'QUANTITATIVE' as a new LAB FILE TEST NAME (the 1ST for
this LAB GROUP NAME)? No// Y (Yes)
```

Limit your selection list for the next prompt by entering the exact name of the lab test or by presenting the program with a hint such as VIRAL or HIV.

```
  Select LOCAL LAB FILE NAME: HIV
```

```
     1   HIV (ELISA)
     2   HIV RNA PCR
     3   HIV VIRAL LOAD
CHOOSE 1-3: 3  HIV VIRAL LOAD
  Are you adding 'HIV VIRAL LOAD' as a new LOCAL LAB FILE NAME (the 1ST
for this LAB FILE TEST NAME)? No// Y (Yes)
    NATIONAL LAB FILE LINK: HIV
     1   HIV       87448.0000
     2   HIV 1 P24 Ag by EIA       89101.0000
     3   HIV 1 by EIA       89098.0000
     4   HIV 1 by IFA       89100.0000
     5   HIV 1 by Western Blot       89099.0000
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: <RET>
     6   HIV 2       88989.0000
     7   HIV Ab       89072.0000
     8   HIV Ab Blood Donor       86170.0000
     9   HIV Ag       89071.0000
     10  HIV Qual       88991.0000
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-10: <RET>
     11  HIV Quant       88990.0000
     12  HIV VIRAL ANTIGEN  Viral Load     87421.0000
     13  HIV Viral Load       89498.0000
     14  HIV Viral Load Ultra       87423.0000
     15  HIV-1 RNA Quant       89180.0000
CHOOSE 1-15: 13  HIV Viral Load     89498.0000
  Select LOCAL LAB FILE NAME: <RET>
Select TYPE OF LAB TEST: <RET>
Select LAB GROUP NAME: <RET>
```

Encryption of Data (Demonstration) (IMR SHOW CODE)

Description:

This option is designed to demonstrate the appearance of patient name, SSN, date of birth (DOB), etc. when encoded for transmission within the ICR package. The ICR entry number is the encoded value of the internal entry number for the Patient (#2) file, giving the file pointer capabilities, when accessed through the routines included in the ICR package.

Field Descriptions:

The user sees the following message when entering the option:
This option demonstrates some of the encryption features for the ICR package. No entries will be made in the Immunology Case Study (#158) file, so you can select any patient to see what he/she would look like.

Patient Name:
Enter the patient's name, last name first.

The following text appears:
Patient's number in the Patient file: ***xxx***
Name: ***patient's name***
SSN: ***social security number***
Date of Birth: ***date of birth***

Patient's id in the Immunology Case Study file: 59556879836
Coded SSN: 59522979559
Coded Date of Birth: 59559012569

V. General Immunology Study Menu

General Immunology Study Menu (IMR MENU (GENERAL))

Description:

This option is used to access the general Immunology Study functions for data entry/editing, and printing of CDC forms.

This menu should be given to clinical staff. The user must have the IMRA key to use any of the options in this menu.

Menu Display:

```
Enter/Edit Basic Patient Data
CDC Form Data Entry
Print CDC Form with Data
Generate a BLANK copy of CDC Form
Patient Inquiry
```

Enter/Edit Basic Patient Data (IMR ENTER/EDIT DATA)

Description:

This is the option used to enter a new patient into the Immunology Case Study (#158) file and to update changes (e.g., category or status).

The patient that you want to add to the Immunology Case Study file must already exist in the facility's Patient (#2) file.

Field Descriptions:

Patient Name:
Enter the patient's name, last name first.

Last T4/CD4 Value:
This is the last T4 or CD4 value available for the patient as entered into this file. This data is updated automatically from the Laboratory database when the data extract job is run.

Last T4/CD4 Date:
This is the date on which the Last T4/CD4 Value (#102.01) field for this patient was obtained.

Lowest CD4 Value Measured:
This is the lowest CD4 value measured for the patient.

Lowest CD4 Value Date:
This is the date on which the Lowest CD4 Value Measured (#102.05) field for this patient was determined.

Lowest CD4 Percentage Measured:
This field is used to hold the lowest CD4 value measured to date for use in checking category 3 AIDS data.

Date for Lowest CD4 Percentage:
This field is used to hold the date associated with the lowest CD4 percentage measured to date.

Category:
The categories for each are as follows:

1. HIV+, CD4+ (T4) count 500/mm3 or greater. Confirmed HIV serum antibody positive (two positive ELISAs and a confirmatory Western Blot). CD4+ (T4) count 500/mm3 or greater.

2. HIV+, CD4+ count between 200 and 500/mm3. Confirmed HIV serum antibody positive (two positive ELISAs and a confirmatory Western Blot). CD4+ (T4) count 200 and 500/mm3.

3. AIDS with CD4+ (T4) less than 200/mm3. Confirmed HIV serum antibody positive (two positive ELISAs and a confirmatory Western Blot). CD4+ (T4) count less than 200/mm3 or CD4+ percent less than 14. No AIDS defining diseases. See below (Category 4).

4. AIDS with AIDS defining diseases. Confirmed HIV serum antibody positive (2 positive ELISAs and a confirmatory Western Blot) as above. CDC defined diseases (see MMWR, December 18, 1992, Vol. 41/RR-17 for listing of AIDS defining diseases).

Date of AIDS Status:
This is the date on which the patient was first considered to be within the AIDS category.

Date of AIDS (CAT 3) Status:
This is the date on which the patient was first considered to be within the AIDS category 3.

Date of HIV+ (CAT 2) Status:
This is the date on which the patient was first considered to have been HIV+ category 2.

Date of HIV+ (CAT 1) Status:
This is the date on which the patient was first considered to have been HIV+.

Want to add a new viral load test for this patient:
The user can add new viral load test results for the patient or edit existing results.

Station:
Enter the facility name.

Patient Status:
This field is used to indicate the patient's status. It is also used in printing the header information on the CDC form. If a date of death is entered in either the Patient file or the Immunology Case Study file, then the field must indicate 'Dead', otherwise the patient must be noted as ‘Alive’ or ‘Unknown’.

Country of Birth (New Form):
This is the country of birth information for this patient for use on the revised CDC form. The options for this information on the new form differ from those available on the earlier CDC form.

Examples:
U.S.
U.S. Dependencies and Possessions (Including Puerto Rico)
Other
Unknown

Race:
This is the patient's race as entered on the CDC form and differs in the handling of hispanic patients from the race field in the Patient file.

Examples:
White (Not Hispanic)
Black (Not Hispanic)
Hispanic
Asian/Pacific Islander
American Indian/Alaskan Native
Not Specified

Local Notification Date (1):
This field is used to indicate the date of a locally relevant notification or other significant event with respect to this patient.

Local Notification Note (1):
This field is used to document a locally relevant notification or other significant event with respect to this patient.

Local Notification Date (2):
The user may enter a second notification date.

Local Notification Note (2):
The user may enter a second notification note.

Local Notification Date (3):
The user may enter a third notification date.

Local Notification Note (3):
The user may enter a third notification note.

Do you want to Enter/Edit CDC form data now?
If you answer No to this question, you will be asked to select another patient's name.

If you answer Yes to this question, you will be prompted for the CDC form data.
Field descriptions for the CDC form data are listed in the following option 'CDC Form Data Entry'.

CDC Form Data Entry (IMR CDC ENTER/EDIT)

Description:

This is the option used to enter the CDC form data which is required prior to printing the CDC form from the Immunology Case Study file.

Field Descriptions:

Patient Name:
Enter the patient's name, last name first.

Select section of CDC form for editing:

Patient ID Header (not edited)
Health Dept. Info (not edited)
1. **Demographic Information**
2. **Facility of Diagnosis**
3. **Patient History**
4. **Laboratory Data**

Other Header Data (not edited)
5. **Clinical Status**
6. **Treatment/Services Referrals**
7. **Comments**

8. **The complete form (all of above)**

Select section (1 to 8):
The user can choose which section of the form they want to edit, or they can edit the entire form.

Category:
The categories for each are as follows:

1. HIV+, CD4+ (T4) count 500/mm3 or greater. Confirmed HIV serum antibody positive (two positive ELISAs and a confirmatory Western Blot). CD4+ (T4) count 500/mm3 or greater.

2. HIV+, CD4+ count between 200 and 500/mm3. Confirmed HIV serum antibody positive (two positive ELISAs and a confirmatory Western Blot). CD4+ (T4) count 200 and 500/mm3.

3. AIDS with CD4+ (T4) less than 200/mm3. Confirmed HIV serum antibody positive (two positive ELISAs and a confirmatory Western Blot). CD4+ (T4) count less than 200/mm3 or CD4+ percent less than 14. No AIDS defining diseases. See below (Category 4).

4. AIDS with AIDS defining diseases. Confirmed HIV serum antibody positive (2 positive ELISAs and a confirmatory Western Blot) as above. CDC defined diseases (see MMWR, December 18, 1992, Vol. 41/RR-17 for listing of AIDS defining diseases).

Date of HIV+ (CAT 1) Status:
This is the date on which the patient was first considered to have been HIV+.

Date of AIDS Status:
This is the date on which the patient was first considered to be within the AIDS category.

1) Demographic Information.

Date CDC Form Completed:
This field is used to track the date on which the CDC form was completed.

Station:
Enter the facility name.

Status at Report:
This field is used to indicate the status of the patient at the time a CDC form is generated. If the user has not entered a value previously the default will be based on the current category shown for the patient. The status can be either HIV (Not AIDS) or AIDS.

Date of Birth:
This field contains the date of birth, this field is not editable.

Age at HIV Diagnosis:
This field contains the age at which HIV was diagnosed in this patient.
This data is used on the CDC form.

Age at AIDS Diagnosis:
This field is used to indicate the patient's age at the time that the diagnosis of AIDS was made. The field is used to print part of the header information on the CDC form.

Patient Status:
This field is used to indicate the patient's status. It is also used in printing the header information on the CDC form. If a date of death is entered in either the Patient file or the Immunology Case Study file, then the field must indicate 'Dead', otherwise the patient must be noted as ‘Alive’ or ‘Unknown’.

Race:
This is the patient's race as entered on the CDC form and differs in the handling of hispanic patients from the race field in the Patient file.

Examples:
White (Not Hispanic)
Black (Not Hispanic)
Hispanic
Asian/Pacific Islander
American Indian/Alaskan Native
Not Specified

Country of Birth (New Form):
This is the country of birth information for this patient for use on the revised CDC form. The options for this information on the new form differ from those available on the earlier CDC form.

Examples:
U.S.
U.S. Dependencies and Possessions (Including Puerto Rico)
Other
Unknown

City at Onset of Illness/AIDS:
This is the city in which the patient was residing at the onset of an illness suggestive of AIDS. This field is used in printing part 1 of the CDC form.

County - Onset of Illness/AIDS:
This field is used to indicate the county in which the patient was residing at the onset of an illness suggestive of AIDS. This field is used in printing part 1 of the CDC form.

State at Onset of Illness/AIDS:
This field is used to indicate the state in which the patient was residing at the onset of an illness suggestive of AIDS. This field is used in printing part 1 of the CDC form.

Country-Onset of Illness/AIDS:
This field is used to indicate the country in which the patient was residing at the onset of an illness suggestive of AIDS. This field is used in printing part 1 of the CDC form.

Zip Code Onset Illness/AIDS:
This field is used to indicate the zip code in which the patient was residing at the onset of an illness suggestive of AIDS. This field is used in printing part 1 of the CDC form.

2) Facility of Diagnosis.

Hospital where AIDS Diagnosed:
This field contains the name of the hospital where the diagnosis of AIDS was first made. This field is used in printing part 1 of the CDC form.

City of Hospital Where AIDS Dx:
This field contains the city in which the hospital is located where the diagnosis of AIDS was first made. This field is used in printing part 1 of the CDC form.

State of Hospital - AIDS Dx:
This field contains the state in which the hospital is located where the diagnosis of AIDS was first made. This field is used in printing part 1 of the CDC form.

Country of Hospital where AIDS Dx:
This field contains the country in which the hospital is located where the diagnosis of AIDS was first made. This field is used in printing part 1 of the CDC form.

Facility Setting:
This field is used to contain data related to the facility setting where the diagnosis was first made. The facility setting is public, private, federal or unknown. This field is used on the CDC form.

Facility Type (AIDS Dx):
This field holds information on the type of facility in which the diagnosis was originally made for this patient. This information is used to generate the CDC form. If the patient was diagnosed at a VA facility under outpatient care, the appropriate response would be 'Other'.

Examples:
Physician,HMO
Hospital,Inpatient
Other

3) Patient History.

After 1977 and preceding the first positive HIV antibody test or AIDS diagnosis, this patient had (respond to all categories):

Sex Relations with Male Partner:
This field contains the answer to the question 'Did this patient after 1977 and preceding the diagnosis of AIDS, have sexual relations with a male partner?' The field is used on the CDC form. The user can answer with 'Yes', 'No' or 'Unknown'.

Sex Relations with Female Partner:
This field contains the answer to the question 'Did this patient, after 1977 and preceding the diagnosis of AIDS, have sexual relations with a female partner?' The field is used on the CDC form. The user can answer with 'Yes', 'No' or 'Unknown'.

IV Drugs After 1977 and Pre HIV:
This field is used to indicate whether the patient used needles for self-injection of drugs not prescribed by a physician during the period after 1977 and before the diagnosis of AIDS. This field is used on the CDC form. The user can answer with 'Yes', 'No' or 'Unknown'.

Received Clotting Factors:
This field is used in part 2 of the CDC form to indicate whether the patient had received clotting factors in the period between 1977 and the diagnosis of AIDS. The user can answer with 'Yes', 'No' or 'Unknown'.

Heterosexual relations with any of the following:

Sex Relations with IV Drug User:
This field is used to store the answer to the question 'Did this patient have heterosexual relations with any of the following: IV drug user' The response is used on the CDC form. The user can answer with 'Yes', 'No' or 'Unknown'.

Sex Relations with Bisexual Man:
This field contains the answer to the question 'Did this patient have sexual relations with a bisexual man?' The field is used on the CDC form. The user can answer with 'Yes', 'No' or 'Unknown'.

Sex Relations with Hemophilia/Coagulation Disorder:
This field is used to store the answer to the question 'Did this patient have heterosexual relations with any of the following: Person with hemophilia/coagulation disorder.' The response is used on the CDC form. The user can answer with 'Yes', 'No' or 'Unknown'.

Sex Relations with Transfusion Recipient with AIDS:
This field is used to store the answer to the question 'Did this patient have heterosexual relations with any of the following: Blood transfusion recipient with AIDS or documented HIV infection.' This field is used on the CDC form. The user can answer with 'Yes', 'No' or 'Unknown'.

Transplant Recipient with Documented HIV:
This field should reflect whether the patient is a transplant recipient with documented HIV infection. The field is used on the CDC form. The user can answer with 'Yes', 'No' or 'Unknown'.

Sex Relations with a person with AIDS/HIV Infection:
This field is used to store the answer to the question 'Did this patient have heterosexual relations with any of the following: Person with AIDS or documented HIV infection.' This field is used on the CDC form. The user can answer with 'Yes', 'No' or 'Unknown'.

End of heterosexual relations queries

Transfusion After 1977 and Before HIV:
This field is used to indicate if the patient had a transfusion after 1977 and before diagnosis of AIDS. This field is used on the CDC form. The user can answer with 'Yes', 'No' or 'Unknown'.

Date of First Transfusion:
This is the date of the first transfusion after 1977. This field is only required if the patient did have a transfusion after 1977 and before the diagnosis of AIDS, and this is the only risk factor for the patient. This field is used on the CDC form.

Date of Last Transfusion:
This is the date of the last transfusion after 1977. This field is only required if the patient did have a transfusion after 1977 and before the diagnosis of AIDS (Yes to Transfusion After 1977 and Before HIV (#16.14) field), and this is the only risk factor for the patient. This field is used on the CDC form.

Transplant or Artificial Insemination:
This field is used to indicate whether the patient was the recipient of a transplant or artificial insemination following 1977 and prior to being diagnosed as HIV positive. The user can answer with 'Yes', 'No' or 'Unknown'.

Work in Health Care or Laboratory:
After 1977 and preceding the diagnosis of AIDS did the patient work in a health care or clinical laboratory setting? This field is used on the CDC form. The user can answer with 'Yes', 'No' or 'Unknown'.

Occupation:
Enter the patient's occupation.

4) Laboratory Data.

1. HIV Antibody Tests at Diagnosis:
Indicate the first HIV antibody test the patient had at diagnosis.

HIV.1 EIA:
This field is used in filling out part 4 of the CDC form, and indicates whether an ELISA test for HIV was performed, and if so what the result was.

Examples:
Reactive
Nonreactive
Not Done

HIV-1/HIV-2 EIA:
This field is used to hold information on whether an HIV-1/HIV-2 EIA was performed on the patient and, if so, the result. This information is used to generate the CDC form.

Examples:
Positive
Negative
Not Done

HIV-1 Western Blot/IFA:
This field is used in filling out part 4 of the CDC form, and indicates whether a Western Blot test was performed for HIV, and if so what the result was.

Examples:
Reactive
Nonreactive
Inconclusive
Not Done

Other Antibody Test:
This field is used in filling out part 4 of the CDC form, and is used to indicate whether an antibody test for HIV was performed other than the ELISA or Western Blot, and the result of this test.

Examples:
Positive
Negative
Inconclusive
Not Done

HIV-2 Serum EIA Results:
This field is used to enter the results of a test for the HIV-2 virus by serum EIA.

Examples:
Reactive
Non-Reactive
Not Done

HIV-2 Western Blot:
This field is used to hold information on whether an HIV-2 Western Blot test was performed on the patient and, if so, the result of the test. This information is used to generate the CDC form.

Examples:
Positive
Negative
Indeterminate
Not Done

2. Positive HIV Detection test:
Record the earliest positive HIV detection test the patient had.

HIV Culture Detection Test:
This field is used to hold the date on which an HIV culture test first produced a positive result. This information is used to generate the CDC form.

HIV Antigen Detection Test:
This field is used for the date of the first positive HIV antigen detection test which was run. The data is used in generating the CDC form.

HIV PCR, DNA, or RNA Probe:
This field is used to hold the date on which an HIV test involving PCR, DNA or RNA probes first produced a positive result. This information is used to generate the CDC form.

Date of Other Positive Detection Test:
This field is used to hold the date on which a positive HIV detection test was obtained with an "other" type of test. This information is used to generate the CDC form.

The next questions are meant for those cases in which positive tests were not obtained to document the diagnosis of HIV.

Last Documented Negative HIV Test:
This field is used to hold the date on which the patient last had a documented negative HIV test. This information is used to generate the CDC form.

Type for Last Negative Test:
This field is used to hold information on the type of test which resulted in the last documented negative HIV test (Field #111.01). This information is used to generate the CDC form.

Physician Documented Diagnosis:
This field is used to indicate whether a physician has documented the diagnosis of HIV or AIDS in this patient. The information is used to generate the CDC form. The user can answer with 'Yes', 'No' or 'Unknown'.

3. Immunologic Lab Tests:
The request is for immunologic lab test data at or closest to the current diagnostic status.

CD4+ Count for CDC (N/UL):
This field is used to contain the CD4+ count entered for part 6 of the CDC form.

CD4+ Percent for CDC (%):
This field is used to enter the percentage of CD4+ leukocytes present in the leukocyte population. The value is used for part 6 of the CDC form.

CD4 Count First <200:
This field is used to contain the number count for the CD4 count which first was below the value of 200. This information is used to generate the CDC form.

CD4 Percent First <14%:
This field is used to hold the CD4 percentage value which was obtained when the percentage was first below 14%. This information is used to generate the CDC form.

5) Clinical Status.

Record Reviewed:
This field is used to indicate whether the patient's medical record was reviewed prior to submitting the CDC form. The entry is used in the CDC form. Answer 'Yes' or 'No'.

Enter (if known) the date the patient was first diagnosed as asymptomatic HIV.

Date Asymptomatic:
This field is used for a date requested in the Clinical Status portion of the CDC form. The form requests the date the patient was diagnosed as asymtptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy).

Enter (if known) the date the patient was first diagnosed as symptomatic HIV (But not AIDS).

Date Symptomatic:
This field is used for the date requested as symptomatic in the Clinical Status portion of the CDC form.

The following question should be answered only if HIV tests were not positive or not done.

Immunodeficiency that Disqualifies:
This field indicates whether the patient has an immunodeficiency which would disqualify the patient from an AIDS diagnosis. This field is used in the CDC form. The user can answer with 'Yes', 'No' or 'Unknown'.

Select the diseases that apply.
Enter 'N' to remove a disease incorrectly selected.

1. Candidiasis, B, T, or L	**2. Lymphoma, Burkitt's**
3. Candidiasis, Esophageal	**4. Lymphoma, Immunoblastic**
5. Carcinoma, Invasive Cervical	**6. Lymphoma, Primary in Brain**
7. Coccidioidomycosis, Dis/Extrap	**8. Mycobacterium Avium**
9. Cryptococcosis, Extrapulmonary	**10. M. Tuberculosis, Pulmonary**
11. Cryptosporidiosis,Chronic	**12. M Tuberculosis, Extrapulmonary**
13. Cytomegalovirus Disease	**14. Mycobacterium**
15. Cytomegalovirus Retinitis	**16. Pneumocystis Carinii**
17. HIV Encephalopathy	**18. Pneumonia, Recurrent in 12 Mo**
19. Herpes Simplex	**20. Progressive Multifocal Leuko**
21. Histoplasmosis, Dis or Extrap	**22. Salmonella Septicemia**
23. Isosporiasis,Chronic Intest	**24. Toxoplasmosis of Brain**
25. Kaposi's Sarcoma	**26. Wasting Syndrome**

Select Disease:
Select all diseases that apply to this patient.

6) Treatment/Services Referrals.

Has this patient been informed of his/her HIV infection?

Patient Been Informed of HIV:
This field is used to indicate whether the patient has been informed of the diagnosis of HIV infection. The field is used to supply data for the CDC form. The user can answer with 'Yes', 'No' or 'Unknown'.

This patient's partners will be notified about their HIV exposure and counseled by:

Partners Notified by:
This field is used to indicate the entity with responsibility for informing the patient's sexual partners of the patient's HIV infection. The data in this field will be used in the CDC form.

Examples:
Health Dept.
Physician/Provider
Patient
Unknown

Has this patient received or is receiving [have they ever received at any time]?

Received Anti-Retroviral Therapy:
The response should indicate whether the patient has received or is receiving anti-retroviral therapy. The data in this entry is used in generating the CDC form. The user can answer with 'Yes', 'No' or 'Unknown'.

Received PCP Prophylaxis:
The response should indicate whether the patient has received or is receiving PCP prophylaxis. The data in this entry is used in generating the CDC form. The user can answer with 'Yes', 'No' or 'Unknown'.

Is this patient receiving or been referred for HIV related medical services?

HIV Related Medical Services:
This field is used to hold the response related to whether the patient is receiving or has been referred to receive HIV related medical services. This information is used in preparing the CDC form. The user can answer with 'Yes', 'No' or 'Unknown'.

Referral For Substance Abuse -- Not Reporting

Enrolled at Clinical Trial:
This field is used to indicate whether the patient is enrolled in a clinical trial, and which category of clinical trial. The data in this field is used in generating the CDC form. For this field VA care would usually fall under 'Other'

Examples:
NIH Sponsored
Other
None
Unknown

Enrolled at Clinic:
This field is used to indicate whether the patient is enrolled in a clinic, and which category of clinic. The data in this field is used in generating the CDC form.

Examples:
HRSA Sponsored
Other
None
Unknown

Primary Reimburser for Medical Rx:
This field is used to indicate who was the primary reimburser for this patient's medical treatment. The entry is used in the generation of the CDC form. For this prompt VA care would usually fall under 'Other Public Funds'.

Examples:
Medicaid
Primary Ins/HMO
No Coverage
Other Public Funds
Clinical Trial/Government Program
Unknown

Gynecology or Obstetric Care:
For female patients only - Is the patient receiving obstetric or gynecological care? The user can answer with 'Yes', 'No' or 'Unknown'.

Currently Pregnant:
For female patients only - Is the patient currently pregnant? The user can answer with 'Yes', 'No' or 'Unknown'.

Delivered Live Born Infant:
This field is applicable to females only - Has the female patient ever delivered a live born infant? The user can answer with 'Yes', 'No' or 'Unknown'.

Child's Date of Birth:
This field appears if the field Delivered Live Born Infant is answered with 'Yes'. Enter the date of birth of the last child born to a woman patient if the birth date is past 1977.

Child's Hospital of Birth:
This field appears if the field Delivered Live Born Infant is answered with 'Yes'. Enter the name of the hospital (2 to 23 characters) in which the last child was born, if this patient is a woman, and the date of birth is past 1977.

Child's Hospital - City:
This field appears if the field Delivered Live Born Infant is answered with 'Yes'. Enter the name of the city (2-23 characters) in which the child's hospital of birth is located.

Child's Hospital - State:
This field appears if the field Delivered Live Born Infant is answered with 'Yes'. Enter the name of the state in which the child's hospital of birth is located.

7) Comments.

CDC Additional Information/Comments 1 of 3:
This is one of three lines of additional comments or information which can be entered as part 5 of the CDC form.

CDC Additional Information/Comments 2 of 3:
This is the second of three lines of additional comments or information which can be entered as part 5 of the CDC form.

CDC Additional Information/Comments 3 of 3:
This is the third of three lines of additional comments or information which can be entered as part 5 of the CDC form.

Print CDC Form with Data (IMR PRINT CDC FORM)

Description:

This option is used to print the CDC form, including the data contained within the Immunology Case Study file.

This report should only be printed to a secured printer.

Field Descriptions:

Patient Name:
Enter the patient's name, last name first.

Physician Name For Form:
Enter the physician's name that is to appear on the form.

Physician Phone Number:
Enter the following phone number in the format (NNN)NNN-NNNN

Your Office Phone Number:
Enter your Phone Number in the format (NNN)NNN-NNNN

Number of Copies: (1-10):
Enter the number of copies you want to print. This response must be a number between 1-10.

For an example of this report, refer to the following option 'Generate a BLANK Copy of CDC Form'.

Generate a BLANK copy of CDC Form (IMR BLANK CDC FORM)

Description:

This option can be used to generate a blank copy of the CDC form to act as a template for asking questions, etc.

This option asks for a device and then prints the report.

Report Description:

The following is an example of a blank CDC form.

```
I. STATE/LOCAL USE ONLY

Patient's Name:                                                                    Phone No.:
 (Last, First, M.I.)
                                                                                                 Zip
Address:                              City:                  County: _____________________  State: ________  Code:


VII. STATE/LOCAL USE ONLY

                                                                                   Medical
Physician's Name:                                        Phone No.:                Record   No.
  (Last, First, M.I.)
                                                  Person
Hospital/Facility:                                Completing Form:                     Phone No.:


This report is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k).  Response in this
base is voluntary for federal government purposes, but may be mandatory under state and local statutes.  Your cooperation is
necessary for the understanding and control of HIV/AIDS.  Information in the surveillance system that would permit identification
of any individual on whom a record is maintained, is collected with a guarantee that it will be held in confidence, will be used
only for the purposes stated in the assurance on file at the local health department, and will not otherwise be disclosed or
released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).


Public burden for this collection of information is estimated to average 10 minutes per response.  Send comments regarding this
burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PHS
Reports Clearance Officer: ATTN: PRA; Hubert H. Humphrey Bldg. Rm 721-B; 200 Independence Ave., SW; Washington, DC 20201, and to
the Office of Management and Budget; Paperwork Reduction Project (0920-0009); Washington, DC 20503. -DO NOT MAIL CASE REPORT FORMS
TO THESE ADDRESSES --


RETURN TO STATE/LOCAL HEALTH DEPARTMENT      - PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC! -

U.S. DEPARTMENT OF HEALTH                    ADULT HIV/AIDS CONFIDENTIAL CASE REPORT                          CDC
& HUMAN SERVICES                          (Patients >=13 years of age at time of diagnosis)          CENTERS FOR DISEASE CONTROL
Public Health Service                                                                                      AND PREVENTION
                                               II. HEALTH DEPARTMENT USE ONLY
DATE FORM COMPLETED
                  ==========================================================================================================
    MO. DAY  YR.       |   SOUNDEX         REPORT STATUS          REPORTING HEALTH DEPARTMENT  STATE                          |
                       |     CODE                                 STATE: _________________       PATIENT NO.: ___________      |
====================   |                   | | NEW REPORT         CITY/                          CITY/COUNTY                   |
| REPORT SOURCE: ___ | |      ____         | | UPDATE             COUNTY:_________________       PATIENT NO.: ___________      |
==========================================================================================================================
-------------------------------------------------  III. DEMOGRAPHIC INFORMATION  ------------------------------------------
DIAGNOSTIC STATUS         AGE AT DIAGNOSIS: |  DATE OF BIRTH  |  CURRENT STATUS  |  DATE OF DEATH  |  STATE/TERRITORY OF DEATH
AT REPORT (check one):                      |   Mo. Day Yr.   |  Alive Dead Unk. |   Mo. Day Yr.   |
|1| HIV Infection (not AIDS)    __ Years    |                 |                  |                 |
|2| AIDS                        __ Years    |   __  __   __   |   |1|  |2|  |9|  |   __  __   __   |
--------------------------------------------------------------------------------------------------------------------------
SEX:       |RACE/ETHNICITY:                                          |COUNTRY OF BIRTH:
|1| Male   ||1| White (not Hispanic) |2| Black (not Hispanic)  |3| Hispanic  ||1| U.S.  |7| U.S. Dependencies and Possessions (in-
|2| Female ||4| Asian/Pacific        |5| American Indian/      |9| Not       |   cluding Puerto Rico (specify): _____________
           |    Islander               Alaskan Native            Specified ||8| Other (specify): _____________   |9| Unknown
--------------------------------------------------------------------------------------------------------------------------
RESIDENCE AT DIAGNOSIS:                      State/
City:                  County:               Country:                                  Zip Code:
--------------------------------------------------------------------------------------------------------------------------
```

IV. FACILITY OF DIAGNOSIS

FACILITY NAME: _____

City _____

State/Country _____

FACILITY SETTING (check one)
|1| Public |2| Private
|3| Federal |9| Unknown

FACILITY TYPE (check one)
|01| Physician,HMO
|31| Hospital,Inpatient
|88| Other (specify): _____

V. PATIENT HISTORY

AFTER 1977 AND PRECEDING THE FIRST POSITIVE HIV ANTIBODY TEST
OR AIDS DIAGNOSIS, THIS PATIENT HAD (Respond to ALL Categories):

	Yes	No	Unk.
* Sex with male	|1|	|0|	|9|
* Sex with female	|1|	|0|	|9|
* Injected nonprescription drugs	|1|	|0|	|9|
* Received clotting factor for hemophilia/coagulation disorder	|1|	|0|	|9|
Specify disorder: |1| Factor VIII |2| Factor IX |8| Other			
* (Hemophilia A) (Hemophilia B) (specify): _____			
* HETEROSEXUAL relations with any of the following:			
* Intravenous/injection drug user	|1|	|0|	|9|
* Bisexual male	|1|	|0|	|9|
* Person with hemophilia/coagulation disorder	|1|	|0|	|9|
* Transfusion recipient with documented HIV infection	|1|	|0|	|9|
* Transplant recipient with documented HIV infection	|1|	|0|	|9|
* Person with AIDS or documented HIV infection, risk not specified	|1|	|0|	|9|
* Received transfusion of blood/blood components (other than clotting factor)	|1|	|0|	|9|
* Received transplant of tissue/organs or artificial insemination	|1|	|0|	|9|
* Worked in a health-care or clinical laboratory setting	|1|	|0|	|9|

Mo. Yr. (FIRST __ __ LAST __ __)
(specify occupation): _____

VI. LABORATORY DATA

1. HIV ANTIBODY TESTS AT DIAGNOSIS: (Indicate FIRST test)	Pos	Neg	Ind	Not Done	Test Date Mo. Yr.
* HIV-1 EIA	|1|	|0|	-	|9|	__ __
* HIV-1/HIV-2 combination EIA	|1|	|0|	-	|9|	__ __
* HIV-1 Western blot/IFA	|1|	|0|	|8|	|9|	__ __
* Other HIV antibody test (specify): _____	|1|	|0|	|8|	|9|	__ __
* HIV-2 EIA	|1|	|0|	-	|8|	__ __
* HIV-2 Western blot	|1|	|0|	|8|	|9|	__ __

2. POSITIVE HIV DETECTION TEST: (Record earliest test)	Mo. Yr.
* HIV culture	__ __
* HIV antigen test	__ __
* HIV PCR, DNA or RNA probe	__ __
* Other (specify): _____	__ __

* Date of last documented NEGATIVE HIV test (specify type): _____	Mo. Yr. __ __
* If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician?	Yes |1| No |0| Unk. |9|
* If yes, provide date of documentation by physician	__ __

3. IMMUNOLOGIC LAB TESTS: At or closest to current diagnostic status	Mo. Yr.
* CD4 Count ..... _,___ cells/uL	__ __
* CD4 Percent ..... __ %	__ __
First <200 uL or <14%	
* CD4 Count ..... _,___ cells/uL	__ __
* CD4 Percent ..... __ %	__ __

VIII. CLINICAL STATUS

CLINICAL RECORD REVIEWED |1| |0|

ENTER DATE PATIENT WAS DIAGNOSED AS: (including acute retroviral syndrome and persistant generalized lymphadenopathy): __ __

Asymptomatic Mo. Yr. __ __

Symptomatic (not AIDS): Mo. Yr. __ __

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo. Yr.
Candidiasis, bronchi, trachea, or lungs	|1|	NA	__ __
Candidiasis, esophageal	|1|	|2|	__ __
Carcinoma, invasive cervical	|1|	NA	__ __
Coccidioidomycosis, disseminated or extrapulmonary	|1|	NA	__ __
Cryptococcosis, extrapulmonary	|1|	NA	__ __
Cryptosporidiosis, chronic intestinal (> 1 month duration)	|1|	NA	__ __
Cytomegalovirus disease (other than in liver, spleen or nodes)	|1|	NA	__ __
Cytomegalovirus retinitis (with loss of vision)	|1|	|2|	__ __
HIV encephalopathy	|1|	NA	__ __
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis, or esophagitis	|1|	NA	__ __
Histoplasmosis, disseminated or extrapulmonary	|1|	NA	__ __
Isosporiasis, chronic intestinal (>1 mo. duration)	|1|	NA	__ __
Kaposi's sarcoma	|1|	|2|	__ __
Lymphoma, Burkitt's (or equivalent term)	|1|	NA	__ __
Lymphoma, Immunoblastic (or equivalent term)	|1|	NA	__ __
Lymphoma, primary in brain	|1|	NA	__ __
Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary	|1|	|2|	__ __
M. tuberculosis, pulmonary *	|1|	|2|	__ __
M. tuberculosis, disseminated or extrapulmonary *	|1|	|2|	__ __
Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	|1|	|2|	__ __
Pneumocystis carinii pneumonia	|1|	|2|	__ __
Penumonia, recurrent in 12 mo. period	|1|	|2|	__ __
Progressive multifocal leukoencephalopathy	|1|	NA	__ __
Salmonella septicemia, recurrent	|1|	NA	__ __
Toxoplasmosis of brain	|1|	|2|	__ __
Wasting Syndrome due to HIV	|1|	NA	__ __

Def.=definitive diagnosis Pres.=presumptive diagnosis

* RVCT CASE NO.: _____

* If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition |1| Yes |0| No |9| Unknown

IX. TREATMENT/SERVICES REFERRALS

Has this patient been informed of his/her HIV infection? |1| Yes |0| No |9| Unk. This patient's partners will be notified about their HIV exposure and counseled by: |1| Health department |2| Physician/provider |3| Patient |9| Unknown	This patient is receiving or has been referred for: Yes No Unk. * HIV related medical services * Substance abuse treatment services	
This patient received or is receiving: * Anti-retroviral therapy Yes |1| No |0| Unk. |9| * PCP prophylaxis Yes |1| No |0| Unk. |9|	This patient has been enrolled at: Clinical Trial: |1| NIH-sponsored |2| Other |3| None |9| Unknown Clinic: |1| HRSA-sponsored |2| Other |3| None |9| Unknown	This patient's medical treatment is PRIMARILY reimbursed by: |1| Medicaid |2| Private ins/HMO |3| No coverage |4| Other public funds |7| Clinical trial/government program |9| Unknown
FOR WOMEN: *This patient is receiving or has been referred for gynecological or obstetrical services: . |1|Yes |0|No |9|Unk *Is this patient currently pregnant? ..... |1|Yes |0|No |9|Unk *Has this patient delivered live born infants? ... |1|Yes (If delivered after 1977, provide birth information below for the most recent birth) |0|No |9|Unk		
CHILD'S DATE OF BIRTH: Mo. Day Yr.	Hospital of Birth: _____ City: _____ State: __	Child's Soundex: | | | | | _____ Child's State Patient No. | | | | | | | | | |

X. COMMENTS:

_____

_____

_____

Patient Inquiry (IMR PATIENT INQUIRY)

Description:

This option allows the user to do a patient inquiry to the local database.

If any of the patient's lab data is purged the user is prompted to do an inquiry to the national database. The local inquiry is also displayed to the user.

Field Descriptions:

Patient Name:
Enter the patient's name, last name first.

Want to include all CD4, ELISA, Western Blot and Viral Load test results for a specified date range?
Print data for a specified date range, or print all data.

Start Date for Period:
Enter the start date for the report.

End Date for Period:
Enter the ending date for the report.

If there is archived data the following message appears:

The Data you are requesting may be purged.

Do You Want To Query the National Data Base For the Report?
If the user answers 'Yes' to this question, the report will be put into a mail message and sent to the user. Then the user may run the report from the local database.
If the user answers 'No', then the user only gets the report from the local database.

Return Report Requested in Delimited Form?
Answer 'Yes' or 'No'. 'Yes' means the data is parsed out in pieces. Users can use the delimited format to place data from the mail message into their favorite analysis software (e.g., EXCEL). 'No' means the report appears in the mail message as it appears on the terminal or in printed form.

You Will Receive a Report From the National Registry in a MailMan message.

Sending Request Message to the National Registry...
Done...

The user can send a National Registry inquiry and then proceed to run the local report if they wish to.

Report Description:

This report contains the following information:

Name of the patient.
SSN.
Gender.
Age.

A patient's demographic data:
Race
Date of HIV+ (Cat 1) Status
Date of HIV+ (Cat 2) Status
Date of AIDS (Cat 3) Status
Date of AIDS Status
Category
Date CDC Form Completed
Station
Status at Report
Age at HIV Diagnosis
Age at AIDS Diagnosis
Patient Status
IMR Date of Death
State/Territory of Death
Country of Birth (New Form)
Dependency or Possession Name
Other Country Description
City at Onset of Illness/AIDS
County - Onset of Illness/AIDS
State at Onset of Illness/AIDS
Country-Onset of Illness/AIDS
Zip Code Onset Illness/AIDS
Local Notification Date (1)
Local Notification Note (1)
Local Notification Date (2)
Local Notification Note (2)
Local Notification Date (3)
Local Notification Note (3)

Facility of diagnosis data:
Hospital where AIDS Diagnosed
City of Hospital where AIDS Dx
State of Hospital - AIDS Dx
Country of Hospital where AIDS Dx
Facility Setting
Facility Type (AIDS Dx)
Other Facility Type

Patient history data:
Sex Relations with Male Partner
Sex Relations with Female Partner
IV Drugs After 77 and Pre HIV
Received Clotting Factors
Type of Hemophilia
Other Hemophilia Description
Sex Relations with IV Drug User
Sex Relations with Bisexual Man
Sex Relations with Person with Hemophilia/Coagulation Disorder
Sex Relations with Transfusion Recipient with AIDS
Transplant Recipient with Documented HIV
Sex Relations with an AIDS/HIV Infected Person
Transfusion After 77 and Before HIV
Date of First Transfusion
Date of Last Transfusion
Transplant or Artificial Insemination
Work in Health Care or Lab
Occupation

Test results data:
HIV.1 EIA
Date-HIV.1 EIA
HIV-1/HIV-2 EIA
HIV-1/HIV-2 EIA Date
HIV-1 Western Blot/IFA
Date-HIV.1 Western Blot
Other Antibody Test
Date-HIV.1 Other Test
Other Antibody Test Description
HIV-2 Serum EIA Results
Date-HIV.2 EIA Test
HIV-2 Western Blot
HIV-2 Western Blot Date
HIV Culture Detection Test
HIV Antigen Detection Test
HIV PCR, DNA, or RNA Probe
Date Other Positive Detection Test
Type of Other Positive Test
Last Documented Negative HIV Test
Type for Last Negative Test
Phys Documented Diagnosis
Date Phys Documented Diagnosis
CD4+ Count for CDC (N/UL)
Date-T4 (CD4+) Count for CDC
CD4+ Percent for CDC (%)

CD4 % Current Diagnosis - Date
CD4 Count First <200
CD4 Count First <200 Date
CD4 Percent First <14%
CD4 Percent First <14% Date
Lowest CD4 Value Measured
Lowest CD4 Value Date

Viral Load Tests:
Lab Test Name
Highest Value
Date of Highest Value
Current Value
Date of Current Value

Clinical status data:
Record Reviewed
Date Asymptomatic
Date Symptomatic
Immunodeficiency that Disqualifies

Treatment/Services referrals data:
Patient Been Informed of HIV
Partners Notified By
Received Anti-Retroviral Therapy
Received PCP Prophylaxis
HIV Related Medical Services
Enrolled at Clinical Trial
Enrolled at Clinic
Primary Reimburser for Medical Rx

Other data:
CDC Additional Information and Comments 1 of 3
CDC Additional Information and Comments 2 of 3
CDC Additional Information and Comments 3 of 3

Disease data:
Date - Candidiasis Bronch...
Date - Candidiasis, Esophageal
Date - Carcinoma, Invasive
Date - Coccidioidomycosis
Date - Cryptococcosis, Extra
Date - Cryptosporidiosis, Chron
Date - Cytomegalovirus Disease
Date - Cytomegalovirus Retinitis
Date - HIV Encephalopathy
Date - Herpes Simplex

Date - Histoplasmosis
Date - Isosporiasis
Date - Kaposi's Sarcoma
Date - Burkitt's Lympho
Date - Immunoblastic Lymph
Date - Primary Brain Lymph
Date - Mycobacterium Avium
Date - Pulmonary TB
Date - Extrapulmonary TB
Date - Other Mycobacterium
Date - Pneumocystis Carinii
Date - Recurrent Pneumonia
Date - Leukoencephalopathy
Date - Recurrent Salmonella
Date - Toxoplasmosis of Brain
Date - Wasting Syndrome HIV
Date - HIV.1 EIA
Date - HIV.1 Western Blot
Date - HIV.1 Other Test
Date - HIV.2 EIA Test
Date - T4 (CD4+) Count for CDC

Most Recent Immunizations:
Date - Last Hepatitis A
Date - Prior Hepatitis A
Date - Last Hepatitis B
Date - Prior Hepatitis B
Date - Prior Hepatitis B
Date - Influenza
Date - Tetanus Diptheria (Adult)
Date - Pneumococcal

VI. Reports Menu (ICR)

Reports Menu (ICR) (IMR PRINT OPTS)

Description:

This menu contains those options for producing output reports based on inclusion in the Immunology Case Study file.

This menu should be given to clinical staff.

Menu Display:

```
Registry List
Breakdown of Patients by Category
Current Inpatients Report
Inpatient and Outpatient Activity
Laboratory Utilization Data
Pharmacy Prescription Utilization Data
Radiology Utilization Report
Follow Up Report
Specific Inpatient/Outpatient Utilization
Utilization of Specific Lab Tests
Drug Specific Utilization Report
Inquiry To National Data Base
Pneumococcal Immunization Report
Viral Tests List
```

Registry List (IMR PATIENT LIST)

Description:

This option will produce a simple listing of patients in the Immunology Case Study file. The listing includes Patient Name, Social Security Number, CAT (Category on a 1 to 4 scale), and if there is a date of death in either the Patient (#2) file or the Immunology Case Study (#158) file, the date of death.

The user is asked on selecting the option whether a listing by Category is desired. If the response is Yes, then the output will be arranged in alphabetical order within categories, otherwise the output will be in simple alphabetical order.

The user is asked to include patients who are alive, deceased, or all patients.

Field Descriptions:

Include only patients seen during a specified period?
The user can print a report for a specified time period, or print all data.

Start Date for Period:
Enter the start date for the report.

End Date for Period:
Enter the ending date for the report.

Type of Patients:
The user can print a report on live patients, deceased patients or both.

Do you want the list sorted by Category (Y/N)?
The user can sort the report by category.

Report Description:

This report contains the following information:

Name of the patient.
Social security number of the patient.
Category of the patient.
Date of death if the patient is deceased.

Breakdown of Patients by Category (IMR CATEGORY BREAKDOWN)

Description:

This option produces a breakdown of patients within various groupings (age, sex, living status, eligibility, means test group, etc.) by their category within the Immunology Case Study file. If a date range is specified, the categories will also be shown for patients seen during that period of time as outpatients, inpatients, who had prescriptions filled, and laboratory tests performed. The other breakdowns will appear only for those patients seen during the specified period.

The user is prompted to do an inquiry from the national database if any of the data from the local database is purged.

Field Descriptions:

One of the following messages will appear when entering this option:

If all entries in the Immunology Case Study file contain category data, the following message is printed:
Checking for entries in the ICR file without category data.
None found.

If entries are found in the Immunology Case Study file with no category data, the following message is printed:
There are *xx* entries in the Immunology Case Registry file with no category indicated --

Then the name and SSN of the patient(s) are displayed on the screen.

Include only patients seen during a specified period?
The user can print a report for a specified period, or print all data.

If the user answers 'Yes' to the previous question the following questions will appear:
Start Date for Period:
Enter the start date for the report.

End Date for Period:
Enter the ending date for the report.

If the user answers 'No' the following question will appear:
Include only living in stats?

Do you want a list of patients with MISSING data elements?
Prints a list of patients with missing data elements if your answer is 'Yes'. This list includes the patient's name, SSN, gender, date of birth, risk code, race, eligibility code, and period of service.

If there is archived data the following message appears:

The Data you are requesting may be purged.

Do You Want To Query the National Data Base For the Report?
If the user answers 'Yes' to this question, the report will be put into a mail message and sent to the user. Then the user may run the report from the local database.
If the user answers 'No', then the user only gets the report from the local database.

Return Report Requested in Delimited Form?
Answer 'Yes' or 'No'. 'Yes' means the data is parsed out in pieces. Users can use the delimited format to place data from the mail message into their favorite analysis software (e.g., EXCEL). 'No' means the report appears in the mail message as it appears on the terminal or in printed form.

You Will Receive a Report From the National Registry in a MailMan message.

Sending Request Message to the National Registry...
Done...

The user can send a National Registry inquiry and then proceed to run the local report if they wish to.

Report Description:

This report contains the following information:

Name of the patient.
Social security number of the patient.
Category of the patient.

This report can be sorted by category. Sub-totals and totals are grouped by alive/dead, gender, age group, means test/eligibility and whether the cases were seen as inpatient or outpatient.

Current Inpatients Report (IMR INPAT LIST)

Description:

This option produces a list of those members of the Immunology Case Study file who are currently inpatients, including their location.

Field Descriptions:

Number of Copies: (1-20):
Enter the number of copies you want to print. This response must be a number between 1-20.

Report Description:

This report contains the following information:

Name of the patient.
Last four numbers of the patient's SSN.
Category of the patient.
Ward the patient is currently on.
Patient's admission date.
Current length of stay.
Year to date length of stay.

Inpatient and Outpatient Activity (IMR IP/OP ACTIVITY LIST)

Description:

This option provides a listing of selected inpatient and outpatient activity during a specified time for members of the Immunology Case Study file. Outpatient activity indicates the number of visits and number of patients involved for each stop code. Inpatient activity indicates the number of patients at each of 1 stay, 2 stays, etc., and the number of patients, stays, total days of inpatient activity, and the median length of stay for each bed section.

Field Descriptions:

Start Date for Period:
Enter the start date for the report.

End Date for Period:
Enter the ending date for the report.

Print Data by CATEGORY as well as totals?
The user can sort data by category.

Report Description:

This report contains the following information:

Name of the stop code.
Number of patients in that stop code.
Number of stays in that stop code.
Number of days at stop code.
Median length of stay.
Average length of stay.

At the end of the report the user is asked to enter the number of users to identify who use the most resources. If the user enters '0', the report ends. Otherwise the report identifies the specified number of individuals as using the greatest amount of resources during the specified time period for the report.

This part of the report contains the following information:

Highest Number of Stays

Patient's name.
SSN.
Number of times the patient stayed in the hospital.
Number of days the patient stayed in the hospital.

Highest Number of Days

Patient's name.
SSN.
Number of times the patient stayed in the hospital.
Number of days the patient stayed in the hospital.

Laboratory Utilization Data (IMR LAB UTILIZATION LIST)

Description:

This option provides a breakdown of utilization of laboratory resources by patients in the Immunology Case Study file. The number of individual laboratory results (each individual result value) and the number of patients generating that workload during a specified time. The number of laboratory values per patient, and the number of patients in each set, the number of patients and results reported by laboratory test type, and the highest number of results per patient and the number of patients at that level for each type of test. These are listed in the order of highest utilization first.

This option can also be used by Laboratory personnel. However, they will not be given the opportunity to see specific patients in order to preserve patient confidentiality.

The user is prompted to do an inquiry from the national database if any of the data from the local database is purged.

Field Descriptions:

Start Date for Period:
Enter the start date for the report.

End Date for Period:
Enter the ending date for the report.

Minimum number of results reported for a test to be listed:
Print the minimum number of results reported for a test to be listed.

Print Data by CATEGORY as well as totals?
The user can sort data by category.

If there is archived data the following message appears:

The Data you are requesting may be purged.

Do You Want To Query the National Data Base For the Report?
If the user answers 'Yes' to this question, the report will be put into a mail message and sent to the user. Then the user may run the report from the local database.
If the user answers 'No', then the user only gets the report from the local database.

Return Report Requested in Delimited Form?
Answer 'Yes' or 'No'. 'Yes' means the data is parsed out in pieces. Users can use the delimited format to place data from the mail message into their favorite analysis software (e.g., EXCEL). 'No' means the report appears in the mail message as it appears on the terminal or in printed form.

You Will Receive a Report From the National Registry in a MailMan message.

Sending Request Message to the National Registry...
Done...

The user can send a National Registry inquiry and then proceed to run the local report if they wish to.

Report Description:

This report contains the following information:

Name of the test.
Number of results reported for that test.
Number of patients who had that test.
Maximum number of results per patient.
Number of patients in parenthesis.

At the end of the report the user is asked to enter the number of users to identify who use the most resources. If the user enters '0', the report ends. Otherwise the report identifies the specified number of individuals as using the greatest amount of resources during the specified time period for the report.

This part of the report contains the following information:

Name of the patient.
SSN.
Number of orders for that patient.
Number of results for that patient.
Number of different lab tests for that patient.

Pharmacy Prescription Utilization Data (IMR PHARM UTILIZATION LIST)

Description:

This option produces a listing of prescription drug utilization by members of the Immunology Case Study file. Drugs with the greatest utilization in terms of fills and in terms of cost of dispensed drugs are listed for the period specified.

This option can also be used by Pharmacy personnel. However, they will not be given the opportunity to see specific patients in order to preserve patient confidentiality.

The user is prompted to do an inquiry from the national database if any of the data from the local database is purged.

Field Descriptions:

Start Date for Period:
Enter the start date for the report.

End Date for Period:
Enter the ending date for the report.

Minimum number of fills to display:
This is the minimum number of fills of a drug to display.

Minimum dollar cost of dispensed fills to display:
This is the minimum dollar cost of the dispensed fills.

Print Data by CATEGORY as well as totals?
The user can sort data by category.

At this point the user is asked to enter the number of users to identify who use the most resources. If the user enters '0', the report does not print the patients who used the most resources. Otherwise the report identifies the specified number of individuals as using the greatest amount of resources during the specified time period for the report.

If there is archived data the following message appears:

The Data you are requesting may be purged.

Do You Want To Query the National Data Base For the Report?
If the user answers 'Yes' to this question, the report will be put into a mail message and sent to the user. Then the user may run the report from the local database.
If the user answers 'No', then the user only gets the report from the local database.

Return Report Requested in Delimited Form?
Answer 'Yes' or 'No'. 'Yes' means the data is parsed out in pieces. Users can use the delimited format to place data from the mail message into their favorite analysis software (e.g., EXCEL). 'No' means the report appears in the mail message as it appears on the terminal or in printed form.

You Will Receive a Report From the National Registry in a MailMan message.

Sending Request Message to the National Registry...
Done...

The user can send a National Registry inquiry and then proceed to run the local report if they wish to.

Report Description:

This report contains the following information:

Name of the drug.
Number of fills for that drug.
Number of patients who had that drug.
Maximum number of fills per patient.
Number of patients in parenthesis.

The next part of the report contains the following information:

Name of the drug.
Current value of the drug.
Number of fills for that drug.
Quantity of drug dispensed.
Number of patients.

The next part of the report contains the following information:

Dollar Cost of Fills

A list of drugs that were encountered with no unit cost data in the Drug file.
Name of the drug.
Number of fills for that drug.
Number of patients who had that drug.
Maximum number of fills per patient.
Number of patients in parenthesis.

Highest Utilization Patients Based on Fills

Patient's name.
SSN.
Total number of fills of the drug for that patient.
Number of different drugs for that patient.
Total cost for that patient.

Highest Utilization Patients Based on Cost

Patient's name.
SSN.
Total number of fills of the drug for that patient.
Number of different drugs for that patient.
Total cost for that patient.

Radiology Utilization Report (IMR RADIOLOGY UTILIZATION)

Description:

This option provides information on the utilization of Radiology resources by individuals within the Immunology Case Study file. The Resource utilization is indicated by the number and types of Radiology Procedures recorded for the specified period of time.

This option can also be used by Radiology personnel. However, they will not be given the opportunity to see specific patients in order to preserve patient confidentiality.

Field Descriptions:

Start Date for Period:
Enter the start date for the report.

End Date for Period:
Enter the ending date for the report.

Minimum number of procedures to display:
Print the minimum number of results reported for a test to be listed.

Print Data by category as well as totals:
The user can sort data by category.

At this point the user is asked to enter the number of users to identify who use the most resources. If the user enters '0', the report does not print the patients who used the most resources. Otherwise the report identifies the specified number of individuals as using the greatest amount of resources during the specified time period for the report.

Report Description:

This report contains the following information:

Total number of each procedure.
Name of the procedure.
Number of patients who had the procedure.

The next part of the report contains the following information:

Name of the procedure.
CPT code for the procedure.
Number of procedures.
Number of patients who had that procedure.

The next part of the report contains the following information:

Highest Utilization Patients Based on Number of Procedures

Patient's name.
SSN.
Total number of procedures for that patient.
Number of different procedures for that patient.

Follow Up Report (IMR FOLLOW UP LIST)

Description:

This option produces a listing of those patients who are at risk for loss to follow-up. The listing is based on patients identified as not having been seen since the date selected by the user. Patients are not listed if there is a date of death in the Patient (#2) file. The listing gives the last date seen, the patient name, the last 4 digits of the social security number and the category by number.

The user is prompted to do an inquiry from the national database if any of the data from the local database is purged.

Field Descriptions:

Number of Days Patients Not Seen:
Enter the number of days since the patient has last been seen. Maximum of 365 days.

If there is archived data the following message appears:

The Data you are requesting may be purged.

Do You Want To Query the National Data Base For the Report?
If the user answers 'Yes' to this question, the report will be put into a mail message and sent to the user. Then the user may run the report from the local database.
If the user answers 'No', then the user only gets the report from the local database.

Return Report Requested in Delimited Form?
Answer 'Yes' or 'No'. 'Yes' means the data is parsed out in pieces. Users can use the delimited format to place data from the mail message into their favorite analysis software (e.g., EXCEL). 'No' means the report appears in the mail message as it appears on the terminal or in printed form.

You Will Receive a Report From the National Registry in a MailMan message.

Sending Request Message to the National Registry...
Done...

The user can send a National Registry inquiry and then proceed to run the local report if they wish to.

Report Description:

This report contains the following information:

Date the patient was last seen.
Name of the patient.
Last four numbers of the patient's SSN.
Category of the patient.

Specific Inpatient/Outpatient Utilization (IMR SPECFC IP/OP ACTIVITY LIST)

Description:

This option will identify those members of the Immunology Case Study file who were seen as outpatients in a specified Stop Code, or as inpatients in a specified bed section. For outpatient activity the desired stop code(s) may be entered directly or by indicating a clinic which falls within the desired stop code. The list is NOT clinic specific, but only uses a specified clinic to identify the stop code and any patients with visits to clinics with that stop code, or interaction with that stop code indicated by Enter/Edit Stop Code will be included.

Field Descriptions:

Start Date for Period:
Enter the start date for the report.

End Date for Period:
Enter the ending date for the report.

Clinic Stop Name:
Enter the name of a clinic stop, the user may select more than one.

Specialty Name:
Answer with the name of a treating specialty, the user may select more than one.

Report Description:

This report contains the following information:

Name of the treating specialty.
Patient name.
SSN.
Admission date.
Length of stay.

Utilization of Specific Lab Tests (IMR SPECFC LAB LIST)

Description:

This option provides identification of patients in the Immunology Case Study File who have had interaction with the laboratory with respect to specific tests designated by the user during a specified period of time.

The user is prompted to do an inquiry from the national database if any of the data from the local database is purged.

Field Descriptions:

Start Date for Period:
Enter the start date for the report.

End Date for Period:
Enter the ending date for the report.

Laboratory Test Name:
Enter the name of a specific laboratory test, the user may select more than one.

If there is archived data the following message appears:

The Data you are requesting may be purged.

Do You Want To Query the National Data Base For the Report?
If the user answers 'Yes' to this question, the report will be put into a mail message and sent to the user. Then the user may run the report from the local database.
If the user answers 'No', then the user only gets the report from the local database.

Return Report Requested in Delimited Form?
Answer 'Yes' or 'No'. 'Yes' means the data is parsed out in pieces. Users can use the delimited format to place data from the mail message into their favorite analysis software (e.g., EXCEL). 'No' means the report appears in the mail message as it appears on the terminal or in printed form.

You Will Receive a Report From the National Registry in a MailMan message.

Sending Request Message to the National Registry...
Done...

The user can send a National Registry inquiry and then proceed to run the local report if they wish to.

Report Description:

This report contains the following information:

Laboratory test name.
Patient name.
SSN.
Number of tests.

Drug Specific Utilization Report (IMR SPECFC RX LIST)

Description:

This option will provide a list of specific patients in the Immunology Case Study file who had prescriptions filled for those particular drugs specified by the user during the selected time period.

The user is prompted to do an inquiry from the national database if any of the data from the local database is purged.

Field Descriptions:

Start Date for Period:
Enter the start date for the report.

End Date for Period:
Enter the ending date for the report.

Drug Generic Name:
Answer with the name of a specific drug, the user may select more than one.

If there is archived data the following message appears:

The Data you are requesting may be purged.

Do You Want To Query the National Data Base For the Report?
If the user answers 'Yes' to this question, the report will be put into a mail message and sent to the user. Then the user may run the report from the local database.
If the user answers 'No', then the user only gets the report from the local database.

Return Report Requested in Delimited Form?
Answer 'Yes' or 'No'. 'Yes' means the data is parsed out in pieces. Users can use the delimited format to place data from the mail message into their favorite analysis software (e.g., EXCEL). 'No' means the report appears in the mail message as it appears on the terminal or in printed form.

You Will Receive a Report From the National Registry in a MailMan message.

Sending Request Message to the National Registry...
Done...

The user can send a National Registry inquiry and then proceed to run the local report if they wish to.

Report Description:

This report contains the following information:

Drug name.
Patient name.
SSN.
Number of fills.
Quantity dispensed.
Current value.

Inquiry to National Data Base (IMR INQUIRY NATIONAL)

Description:

This option allows users to make an inquiry to the National Registry for seven reports. The reports are: Patient Inquiry, Breakdown of Patients by Category, Laboratory Utilization Data, Pharmacy Prescription Utilization Data, Follow Up Report, Utilization of Specific Lab Tests, and Drug Specific Utilization Report.

When generating these reports through the Inquiry to National Data Base option, there are no checks for archived data in the local (facility) database. The reports automatically go to the National Registry to generate the report.

Field Descriptions:

When selecting this option, the user sees a menu with the following reports listed:

Patient Inquiry
Breakdown of Patients by Category
Laboratory Utilization Data
Pharmacy Prescription Utilization Data
Follow Up Report
Utilization of Specific Lab Tests
Drug Specific Utilization Report

For information on these reports, refer to the correct report option in this manual.

Pneumococcal Immunization Report (IMR PNEUMOCOCCAL RPT)

Description:

This option allows the generation of two possible report outputs:

The Pneumo-Vac for a Date Range report output allows a user to enter a date range and then displays the name, SSN and date of immunization for all ICR patients that had a Pneumococcal Immunization within that date range.

The No Pneumo-Vac in 5 Years report output displays the name, SSN and last date of immunization for all living ICR patients who have not had a Pneumococcal Immunization within the last 5 years.

Each report gives the total number of patients in the list.

Field Descriptions:

The Pneumo-Vac for a Date Range report asks for a date range:

Enter Start Date:
Enter the start date for the report.

Enter Ending Date:
Enter the ending date for the report.

Report Description:

Both reports contains the following information:

Patient name.
SSN.
Date of last immunization.

Viral Tests List (IMR VIRAL TESTS LIST)

Description:

This option tallies the test results for Viral Load Tests for a patient. It cannot be requested from the National Registry. At this time users can only tally the test results for a date range that is not before any archive and purge of the lab tests. Also, this option will provide results only when the entry VIRAL LOAD has been added as a LAB - SPECIFIC TEST NAME, and facility lab file test names for viral load are linked to VIRAL LOAD. (See the Enter/Edit Immunology Study Site Parameters [IMR SPF ENTER/EDIT] option in this manual.)

Field Descriptions:

Start Date for Period:
Enter the start date for the report.

End Date for Period:
Enter the ending date for the report.

Report Description:

This report contains the following information:

Test name.
Test result.
Patient name.
SSN.
Number of tests.
Date of test.

VII. Glossary

Access Code A unique sequence of characters known by and assigned only to the user, the system manager and/or designated alternate(s). The access code (in conjunction with the verify code) is used by the computer to identify authorized users.

ADP Coordinator/ADPAC/Application Coordinator Automated Data Processing Application Coordinator. The person responsible for implementing a set of computer programs (application package) developed to support a specific functional area such as Immunology Case Registry, PIMS, etc.

Application A system of computer programs and files that have been specifically developed to meet the requirements of a user or group of users. Examples of V*IST*A applications are the PIMS and Immunology Case Registry application.

Archive The process of moving data to some other storage medium, usually a magnetic tape, and deleting the information from active storage in order to free-up disk space on the system.

Audit Trail/Logging Features The use of automated software procedures to determine if the security controls implemented for protection of computer systems are being circumvented and to identify the potential source of the security breach.

Backup Procedures The provisions made for the recovery of data files and program libraries and for restart or replacement of ADP equipment after the occurrence of a system failure.

Baud Rate The rate at which data is being transmitted or received from a computer. The baud rate is equivalent to the number of characters per second times 10.

Block The unit of storage transferred to and from disk drives, typically 512, 1024, or 2048 bytes (characters).

Boot The process of starting up the computer.

Bulletin A canned message that is automatically sent by MailMan to a user when something happens to the database.

Byte A unit of computer space usually equivalent to one character.

CIOFO Chief Information Office Field Office, formerly known as Information Resource Management Field Office, and Information Systems Center.

Contingency Plan A plan which assigns responsibility and defines procedures for use of the backup/restart/recovery and emergency preparedness procedures selected for the computer system based on risk analysis for that system.

CORE A collection of VA developed programs (specific to PIMS, Pharmacy Service, and Laboratory Service) which is run at VA Medical Centers.

CPU Central Processing Unit, the heart of a computer system.

CRT Cathode Ray Tube, similar to a TV monitor but used in computer systems for viewing data. Also called a Video Display Terminal (VDT).

Cursor A visual position indicator (e.g., blinking rectangle or an underline) on a CRT that moves along with each character as it is entered from the keyboard.

Data Dictionary A description of file structure and data elements within a file.

Device A hardware input/output component of a computer system (e.g., CRT, printer).

Disk A magnetic storage device used to hold information.

Edit Used to change/modify data typically stored in a file.

Field A data element in a file.

File The M construct in which data is stored for retrieval at a later time. A computer record of related information (e.g., Patient file).

File Manager or FileMan Within this manual, FileManager or FileMan is a reference to VA FileMan. FileMan is a set of M routines used to enter, edit, print, and sort/ search related data in a file; a data base.

Global An M term used when referring to a file stored on a storage medium, usually a magnetic disk.

Hardware The physical or mechanical components of a computer system such as CPU, CRT, disk drives, etc.

IRMS Information Resource Management Service.

Kernel A set of software utilities. These utilities provide data processing support for the application packages developed within the VA. They are also tools used in configuring the local computer site to meet the particular needs of the hospital. The components of this operating system include: MenuMan, TaskMan, Device Handler, Log-on/Security, and other specialized routines.

Kilobyte More commonly known as Kbyte or "K". A measure of storage capacity equivalent to 1024 characters.

LAYGO An acronym for Learn As You Go. A technique used by VA FileMan to acquire new information as it goes about its normal procedure. It permits a user to add new data to a file.

M Formerly known as MUMPS or the Massachusetts (General Hospital) Utility Multi-Programming System. This is the programming language used to write all V*IST*A applications.

MailMan An electronic mail, teleconferencing, and networking system.

Megabyte A measure of storage capacity; approximately 1 million characters. Abbreviated as Mbyte or Meg.

Memory A storage area used by the computer to hold information.

Menu A set of options or functions available to users for editing, formatting, generating reports, etc.

Menu Manager A part of the Kernel that allows each site to manage the various options or functions available to individual users.

Modem An electronic device which converts computer signals to enable transmission through a telephone.

Module A component of the Immunology Case Registry software application that covers a single topic or a small section of a broad topic.

Namespace A naming convention followed in the VA to identify various applications and to avoid duplication. It is used as a prefix for all routines and globals used by the application. The Immunology Case Registry Package uses IMR as its namespace.

Operating System The innermost layer of software that communicates with the hardware. It controls the overall operation of the computer such as assigning places in memory, processing input and output. One of its primary functions is interpreting M computer programs into language the system can understand.

Option A functionality that is invoked by the user. The information defined in the option is used to drive the menu system. Options are created, associated with others on menus, or given entry/exit actions. For example, the IMR MENU (MANAGEMENT) is the main menu for the Immunology Case Registry application.

Package Otherwise known as an application. A set of M routines, files, documentation and installation procedures that support a specific function within V*IST*A (e.g., the ADT and Immunology Case Registry applications).

Password A protected word or string of characters that identifies or authenticates a user, a specific resource, or an access type (synonymous with Verify Code).

Pointer A special data type of VA FileMan that takes its value from another file. This is a method of joining files together and avoiding duplication of information.

Port An outlet in the back of the computer into which terminals can be connected.

Printer A device for printing (on paper) data which is processed by a computer system.

Program A set of M commands and arguments, created, stored, and retrieved as a single unit in M.

Queuing The scheduling of a process/task to occur at a later time. Queuing is normally done if a task uses up a lot of computer resources.

Response Time The average amount of time the user must wait between the time the user responded to a question at the terminal and the time the system responds by displaying data and/or the next question.

Restart/Recovery Procedures The actions necessary to restore a system's data files and computational capability after a system failure or penetration.

<RET> Carriage return or Enter.

Routine A set of M commands and arguments, created, stored, and retrieved as a single unit in M.

Security Key A function which unlocks specific options and makes them accessible to an authorized user.

Security System A part of Kernel that controls user access to the various computer applications. When a user signs-on, the security system determines the privileges of the user, assigns security keys, tracks usage, and controls the menus or options the user may access. It operates in conjunction with MenuMan.

Sensitive Information Any information which requires a degree of protection and which should be made available only to authorized users.

Site Configurable A term used to refer to features in the system that can be modified to meet the needs of each site.

Software A generic term referring to a related set of computer programs. Generally, this refers to an operating system that enables user programs to run.

Subroutine A part of a program which performs a single function.

Task Manager or TaskMan A part of Kernel which allows programs or functions to begin at specified times or when devices become available. See Queuing.

Telecommunications Any transmission, emission, or reception of signs, signals, writing, images, sounds or other information by wire, radio, visual, or any electromagnetic system.

Terminal A device used to send and receive data from a computer system (i.e., keyboard and CRT, or printer with a keyboard).

UCI User Class Identifier. The major delimiter of information structure within the operating system.

User A person who enters and/or retrieves data in a system, usually utilizing a CRT.

Utility An M program that assists in the development and/or maintenance of a computer system.

VDT Video Display Terminal. Also called a Cathode Ray Tube (CRT).

Verify Code A unique security code which serves as a second level of security access. Use of this code is site specific; sometimes used interchangeably with a password.

V*IST*A Veterans Health Information Systems and Technology Architecture.

VIII. Appendix A (Worksheet for Lab Test Link)

[1]Use this worksheet to document all your local lab tests that will be linked to those in the National Lab File (WKLD file #64). The entries in your local files may not be the same as the entries listed below in the first three columns, which are shown as examples/references only. If your local names and/or codes are different, fill in the last two columns as needed. This will provide an easy guide when using the option **Link Local Lab to National Lab File** **(IMR LAB TEST ENTRY)**.

Local Lab Test Name (from file #60)	**National Lab Test Name** (from WKLD file #64)	**Workload Code**	**Local National Lab Test Name** (if different from entry in column 2 for your site)	**Workload Code** (if different from entry in column 3 for your site)
Albumin	Albumin	82040.0000		
Alkaline Phosphatase	Alkaline Phosphatase	84075.0000		
ALT	Transferase Alanine Amino SGPT	84465.0000		
Amylase	Amylase	82150.0000		
AST	Transferase Aspartate SGOT	84455.0000		
Bilirubin (Total)	Bilirubin Total	82250.0000		
Bilirubin (Direct)	Bilirubin Direct	82249.0000		
CD4 (Absolute)	CD4 Absolute	86679.0000		
CD4 (Percent)	CD4	86527.0000		
Cholesterol (Total)	Total Cholesterol	82466.0000		
Creatine Kinase (CK)	Creatine Kinase (CK)	82550.0000		
Creatinine	Creatinine	82565.0000		
G6PD	Glucose 6 Phos Dehydrogenase	82955.0000		
Glucose	Glucose Quant	84330.0000		
HDL	Cholesterol HDL	83013.0000		
Hematocrit	HCT Macro or Micro	85055.0000		
Hemoglobin	Hemoglobin	83020.0000		
Hemoglobin A1C	Glycohemoglobin A(1)C	85052.0000		
	Glycohemoglobin HbA 1C	85053.0000		
Hepatitis B Core Ab	Hepatitis B Core Ab	89065.0000		
Hepatitis B Core Ag	Hepatitis B Core Ag	89066.0000		
Hepatitis B Surface Ab	Hepatitis B Surface Ab	89067.0000		

[1] Patch IMR*2.1*8

Local Lab Test Name (from file #60)	**National Lab Test Name** (from WKLD file #64)	**Workload Code**	**Local National Lab Test Name** (if different from entry in column 2 for your site)	**Workload Code** (if different from entry in column 3 for your site)
Hepatitis B Surface Ab (Quant)	Hepatitis B Surface Ab (Quant)	89699.0000		
Hepatitis B Surface Ag	Hepatitis B Surface Ag	89068.0000		
Hepatitis C Antibody	Hepatitis C Ab	89070.0000		
Hepatitis C Antigen	Hepatitis C Ag	87439.0000		
Hepatitis C RNA	Hepatitis C RNA	89485.0000		
Hepatitis C RNA by PCR	Hepatitis C RNA by PCR	89124.0000		
HIV-1 by ELISA	HIV 1 by ELISA	89098.0000		
HIV-1 by IFA	HIV-1 by IFA	89100.0000		
HIV-1 RNA Qual	HIV Qual	88991.0000		
HIV-1 RNA Quant	HIV-1 RNA Quant	89180.0000		
	HIV VIRAL LOAD	89498.0000		
	HIV QUANT	88990.0000		
HIV-1 RNA Quant Ultra	HIV VIRAL LOAD ULTRA	87423.0000		
LDH	Lactate Dehydrogenase	83620.0000		
LDL	Cholesterol LDL	83017.0000		
Neutrophil (percent)	Neutrophil %	85099.0000		
RPR	Rapid Plasma Reagin	89106.0000		
Triglycerides	Triglycerides w o extract	84480.0000		
VDRL	VDRL	89155.0000		
WBC Count	White Blood Cell Count	85030.0000		
	Differential Count WBC	85249.0000		
Western Blot	Western Blot	89099.0000		

IX. Appendix B (ICR Lab Groups and Lab Test Names)

[1]**Lab Group Name**	**Type of Lab Test**
CD4	CD4 Count (absolute) CD4 percent
Viral Load	Qualitative Quantitative Quantitative, Ultra
HIV Antibody	ELISA IFA (Immunofluorescent Antibody)
Lipids	Total Cholesterol HDL (high density lipoproteins) LDL (low density lipoproteins) Triglycerides
Chemistry General	Glucose Creatinine Lactate Dehydrogenase (LDH) Creatine Phosphokinase (CPK) Amylase
Chemistry Liver	AST (Aspartate Transferase) ALT (Alanine Transferase) Total Bilirubin Alkaline Phosphatase Albumin
Blood Counts	Hemoglobin Hematocrit HgbA1C (glycohemoglobin) White Blood Cell count White Blood Cell -- percent neutrophil G6PD (Glucose-6-Phosphodehydrogenase)
Serology—Hepatitis	HepBsAg (Hepatitis B Surface Antigen) HepBsAb (Hepatitis B Surface Antibody) HepBcAb (Hepatitis B Core Antibody) HepCAb (Hepatitis C Antibody)
Serology—Other	RPR (Syphilis) VDRL (Syphilis) Toxoplasma CMV(Cytomegalovirus)

[1] Patch IMR*2.1*8

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